No. 2
5-42
17-39
X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 6 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37801

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. 1246

1. PLACE OF DEATH:

(a) County Buchanan.
(b) City or town St. Joseph.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital.
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 12 days. (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Buchanan. 011
(c) City or town St. Joseph. 1
(If outside city or town limits, write "RURAL") 1
(d) Street No. 2417 Olive Street.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Vinal Mae Reed.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 1 Female.

5. Color or race White

6. (a) Single, widowed, married, divorced Married.

6. (b) Name of husband or wife Lawrence O. Reed.

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased March (Month) 12 (Day) 1904 (Year)

8. AGE: Years 39 | Months 8 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Smith Center (City, town, or county) Kansas. 1 (State or foreign country)

10. Usual occupation Housewife.

11. Industry or business

MOTHER FATHER

12. Name Frank Ormsbee.

13. Birthplace unknown (City, town, or county) 9 (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Lawrence O. Reed.

(b) Address 2417 Olive Street.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-43 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Herman W. Bideldaden

(b) Address 1802 Union St. St. Joseph Mo.

19. (a) 11-16-43 (Date received local registrar) (b) Rose Degon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12 year 1943 hour 6:05 minute P. M.

21. I hereby certify that I attended the deceased from Jan 1, 19 43, to Nov 12 - 1943; that I last saw h alive on Nov 12, 19 43 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocarditis	1 yr.
Due to Thyroidectomy	1 wk.
Due to	
Other conditions (Include pregnancy within 3 months of death) 0	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. M. Allaman M.D. (M. D. or other)
Address Cameron Mo. Date signed 11/13/43

1233 (Licensed Embalmer's Statement on Reverse Side) St Joseph Mo

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., ..., Registered Apprentice No. ....., working under my personal supervision.

Signed Herman Wm Sidenfaden

Licensed Embalmer No. 2728

P. O. Address St Joseph Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
1—5-43
X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. xlee

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. 1246

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State ____ (b) County ____

(c) City or town ____
(If outside city or town limits, write "RURAL")

(d) Street No. ____
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME Vinal Mae Reed

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased March (Month) 12 (Day) 1904 (Year)

8. AGE: Years 39 | Months 8 | Days ____ | If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Kansas (State or foreign country)

10. Usual occupation ____

11. Industry or business ____

MOTHER FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)

MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)

16. (a) Informant ____
(b) Address ____

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____
(b) Address ____

19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR. Day 12
year 1943 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19__ to ____, 19__; that I last saw h__ alive on ____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocarditis	
Due to Toxic thyroid	
Due to ____	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work ____ (e) Means of injury ____

23. Signature D. H. Allaman (M. D. or other)
Address Medical Bldg St Joseph Mo Date signed ____

SUPPLEMENTARY

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